Ethics of the Distribution of Health Care

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While the concept of a "right to health care" has been evolving in the United States, this should be distinguished from "the right to health," guaranteed in the constitutions of many socialist countries. In an effort to promote "quality of life" for their citizens, governments can, and do, provide health care, but this does not always lead to health. In so doing, governments open access to care for those previously underserved—or unserved. For the United States at this time the goal becomes one of assuring equity, which will likely be achieved by locally based private and/or governmental entities, federated for greater efficiency and regulated by federal and state governments. Such programs will be staffed by a new breed of physician, the medical student of today.

Conventional discussions of medical ethics often ignore or de-emphasize the "ethics of health care distribution" as an issue. There is, rather, an emphasis on such subjects as euthanasia, abortion, organ transplantation, medical jurisprudence, and professional confidentiality.[1] A Medlar II (National Library of Medicine's National Interactive Retrieval Service) search for medical ethics citations relating to three major health care categories produced some 474 references, only 19 of which were judged useful to the topic of health care distribution.

Nonetheless, the ethics of health care distribution is a major, if not *the* major, topic of medical ethics today. This topic includes the organization and distribution of the system within which all other medical ethical issues are to be found. Indeed, the ethics of health care distribution is at the interface of health and society. According to Fletcher:

> It is precisely here, in the social dimension of medicine, that we run into the question of distributive justice, and distributive justice is the core or key all-embracing question for medical ethics. Distributive justice is the biggest or most all-embracing ethical problem.[2]

The Right to Health

Typically, the issue of distributive justice in relation to the problem of health care distribution is approached by medical policy makers as a "right to health." The World Health Organization (WHO) prefaces its famous 1977 call of health for all by the year 2000 with the following: "Considering that health is a basic human right. . . ."[3] Czechoslovakia and other socialist countries rec-

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ognize this ''right'' by incorporating it in their constitutions.[4] Such a constitutional provision could become the basis for a legal claim to health. Whether rights be defined in legal or moral terms, they represent claims individuals have against society.[5] In the minds of many, the ''right to health'' has been an evolving moral, as opposed to legal, concept in the United States.

There are several problems with this approach. The first is definitional. What is health? The World Health Organization definition of health as ''a state of complete physical, mental, and social well being,''[6] while admirable as a utopian goal, is excessively broad in terms of operational implementation. Indeed, there is no way to implement such a policy successfully. It sets an impossible goal for society if all citizens are to have a ''right to health.''

The Relationship of Health and Health Care

The capacity of medicine to deliver ''health,'' in the above sense, is quite limited. Medicine is admittedly technologically powerful. ''Modern medicine . . . commands a powerful arsenal of weapons to forestall death, relieve pain, cure malignancies, and rehabilitate the crippled.''[7] Yet, none of these triumphs assures health in the World Health Organization sense of the term.

This leads to the principal problem associated with attempting to implement a ''right to health.'' That is, health care does not equal health. Wildavsky states the case thus: ''According to the Great Equation, Medical Care equals Health. But the Great Equation is wrong. More available medical care does not equal better health.''[8] He estimates the impact of medical care on health to be 10 percent, with 90 percent determined by lifestyle, social conditions, and the physical environment.

In yet another sense, health care falls short of guaranteeing health. In his book, *Medical Nemesis,* Illich refers to the situation created by the health care establishment. He writes:

> The true miracle of modern medicine is diabolical. It consists not only of making individuals but whole populations survive on inhumanly low levels of personal health. Medical nemesis is the negative feedback of a social organization that set out to equalize and improve the opportunity for each man to cope in autonomy and ended by destroying it.[9]

Speculating on why ''health should decline with increasing health service delivery,'' Illich finds a distant echo in the Roemer and Schwartz study of health statistics during the 1976 Los Angeles County physician slowdown.[10] Mortality indices declined precisely during those times that medical services were withheld, presumably due to postponement of elective surgery. Distinguishing the implications of their study from the conclusions of Illich and others that medical care as a whole does more harm than good, these authors conclude that people might benefit if less elective surgery were performed. Perhaps one day the Surgeon General will warn that ''physicians may be dangerous to your health.''

Yet, even if the implications of what Illich or Roemer and Schwartz have said are correct, people continue to seek out more extensive and expensive forms of medical care. While improved health may not be the result, exercise of this moral ''right to health care'' is increasingly seen as part of the quality of life to which all citizens aspire. According to Fox, ''the medicalization process entails the assertion of various individual and collective rights to which members of the society feel entitled and which they express as 'health,' 'quality of life,' (and) 'quality of death.'''[11] Health care, then, contributes to our perception of health: the quality of our living—and our dying.

Fortunately for government, health care—whatever its value—can be delivered. A moral right is without meaning if it is not deliverable in some sense. Although it may be more effective to attack other problems related to health, eg, smoking, poverty, air pollution, or more judiciously to utilize medical technology, health care is a desired commodity which government can deliver. The nature of the political process is such that this is what government does.

The Problem of Limited Resources

Why, then, not simply provide unlimited access to health care? The answer is twofold: limited resources and unlimited expectations. Mechanic has

said: "No system of care in the world is willing to provide as much care as people will use, and all such systems develop mechanisms that ration . . . services."[12] Access to health care may be limited in many ways: money, distance, complexity, and time. Characteristically, in a free enterprise system, rationing is by money. In socialistic systems, rationing is by time.

Increasingly, the need to live with limited resources is being confronted by the Western world. (This reality has long been appreciated by the rest of the world.) The comforting final nostrum, generally imparted to the bereaved, that "everything was done that could be done," should be dropped or modified. We cannot and should not do everything. As Fletcher observes: "The ethics of delivering health care demands that we face the fact of the limits of growth and resources, the realities of a finite world."[2]

Unfortunately, in health care, expectations run more to the infinite than the finite. Kass has stated: "All kinds of problems now roll to the doctor's door, from sagging anatomies to suicides, from unwanted childlessness to unwanted pregnancy, from marital difficulties to learning difficulties, from genetic counseling to drug addiction, from laziness to crime."[13] One result of such broadly based demands is that classical economic expectations often appear inoperative. Despite the rationing role of money, demand functions are little affected by changing price. Writes Pelligrino: "The usual forces that enable supply and demand to exert reciprocal restraint are absent or obtunded . . . the health care 'market' violates many of the supposedly immutable laws that rule other commodity markets."[14] Demand, in a word, outstrips supply in a setting of limited resource allocation.

If there are not enough health care services, given resources and perceived needs, then the issue (once again) is one of distributive justice. How can a society establish the most equitable allocation of scarce resources? Basically, there are two general approaches.

The first is the utilitarian model. "Utilitarians . . . hold that a person has a moral right to something when his having it would produce a greater balance of satisfaction over dissatisfaction in the world than his not having it would."[5] An example of how this philosophy may be employed is the old renal dialysis program, where individuals who were younger, more responsible, and with higher incomes were more likely to be chosen to receive dialysis than their opposites. This complex decision making process, largely made moot by the federal government's assumption of responsibility for renal dialysis costs, was based on the utilitarian presumption of achieving the greatest good for the greatest number.

The second model which may be employed for the allocation of scarce resources is the contractarian model. "Those who subscribe to this view hold that the basic idea underlying the concept of justice is that of fairness."[5] Based on the social contract, this approach begins with the assumption that all individuals should have equal access to socially desirable programs. Or, according to Outka, access to health care should be equal for people with similar categories of illness.[15] Characteristics such as social class and wealth are seen by Rawls and others as a matter of chance, and therefore irrelevant to distribution of services.[16] Calling this the "egalitarian theory of a just health care delivery," Veatch states: "Justice requires [that] everyone has a claim to health care needed to provide an opportunity for a level of health equal, insofar as possible, to other persons' health."[17] Although equality of health per se is not possible, the contractarian theory calls for equality of access as a means of achieving justice and improving the quality of life.

Should "quality of life" improve as a result of the distribution of health care services, the contractarian formulation may prove preferable to the utilitarian model in a democratic society. Particularly since the relationship between delivery of high technology health care and health outcomes is unclear, little support can be found for targeting such services to the "most worthy." What is needed is a more even distribution of health care services throughout all segments of society. That segment least likely to receive desired health care services today, and thus the one most in need of better access to these services, is the population living in poverty.

The Poor and Distributive Justice

One characteristic of a poverty population is that the poor often do not seek health care, even

when they feel a need for it. As noted by Senator Ted Kennedy:

> When Americans who can pay little or nothing for health care are struck by illness or accident, they have two choices: they can seek treatment from private hospitals and physicians at the risk of being turned away because they cannot pay or they can seek free care from a city or charity hospital where care is frequently demeaning and inadequate. Rather than risk humiliation, they simply avoid taking members of their family for care at all, except in grave emergencies when they have no choice.[18]

If an egalitarian approach is to be followed, in view of the limited resources and disparity of health care currently provided to citizens in the United States, greater attention must be focused on delivering health care services to the poor. In the state of Arizona, for example, this group includes 194,111 individuals out of a population of 2,631,000, or roughly seven percent. Of those identified as poor (by the state's Department of Economic Security), only 90,423 have been "certified eligible" by counties administering indigent health care programs. The question is how best to involve these individuals, both certified and uncertified, in a redistribution of health care. Atypical among the other states in that it does not have Medicaid, Arizona poses a particular problem. The state contributes to a federal redistribution program, but does not benefit from this contribution.

Any redistribution strategy designed to ensure equality of health care is doomed to failure, as is the goal of achieving equal health. The goal, rather, should be equity in health service delivery. "Equity" is here defined as access to the quantity and quality of health care needed to produce essentially equal outcomes in terms of quality of life. The more well-to-do will always be able to purchase supplemental health care (done even in communist countries), but the impact of that additional health care on quality of life should be marginal in an equitable society.

Government's role thus becomes one of assuring that all members of society have reasonable access to health care. Focusing on the population in greatest need, this may be achieved by placing health care services in financial reach of the poor or by making these services more compatible with the needs and expectations of their recipients. In *A Right to Health*, Lewis examines a number of federal programs designed to achieve equity in health care delivery and assesses their effectiveness. They are: (1) practice commitment plus loan forgiveness; (2) rural preceptorships; (3) family practice; (4) increased production of physicians; (5) use of new health care practitioners; (6) National Health Service Corps; (7) Medicare; (8) Medicaid; (9) neighborhood health centers; (10) children and youth programs; and (11) health maintenance organizations.[19] Each is noted to have its limitations and positive attributes—some more positive than others.

The Redistribution of Health Care

Review of the above programs raises a question concerning the extent to which the federal government is needed to achieve the goal of more equitable health care distribution and to what extent this goal could be achieved by private medicine or local and state governments working in concert. One perspective, referencing a meeting of the Pima County (Arizona) Medical Society Legislative Committee addressing the question of "Medical Care for the Indigent" states:

> . . . there seemed to be unanimous agreement . . . that local administration and financing of this care is the most cost effective and the least burdensome upon the people dispensing this care. Using this reasoning, I propose that we return to the old system of delivery of health care to the poor.[20]

Even if the volunteer physicians' approach being called for could successfully provide care for the poor, this would clearly perpetuate a "two class" system of care and, therefore, not be consistent with the concept of equity proposed. Possibly, however, local administrative units, such as state and local governments (with federal government assistance), could establish systems of care that would be available to all segments of society and guarantee a minimally acceptable level of health care delivery.

"Essential" social services are provided, for the most part, in two ways in this society: (1) regulated public utilities, which may be privately owned and operated; or (2) governmental entities. The first may be illustrated by the electric utility,

controlled by a Corporation Commission or its equivalent. The second is exemplified by the public education system, run by a varient of the special district, the independent school district. Not an arm of local government, this body is charged with one function by the state—education of children—and is permitted to tax, bond, and enforce attendance to assure that the mission is fulfilled.

As health care is increasingly perceived as a social right, it may go in either or both of the noted (private or public) directions in order to establish the contractarian principle of equity. For health, the first option might imply large medical care foundations and health maintenance organizations, all closely regulated by the state, but operating privately. The second option might imply creating an entity equivalent to the school district, but whose mission it would be to provide health care services. (Such an option exists under Arizona law and is called the Health Service District.[21]) Either way, there is likely to be a large measure of public involvement in the health care delivery system of the future if distributive justice (or equity) is to be achieved.

Surprising as it may be to liberals, who in recent years have propounded federal solutions to the health care delivery problem while simultaneously extolling the report of the Committee on the Costs of Medical Care, that same committee preferred local control where possible. Their 1932 report stated:

> In the less prosperous sections of the country . . . the Federal government should enable state and local governments to provide a basic minimum of good medical care. In general, a majority of the Committee believe that it is wise never to rely on a larger unit when the cost can be borne by a smaller one.[22]

With the possible exception of the mail, no essential public service in the United States is provided out of Washington, DC. This would make the development of a National Health Service, such as exists in Great Britain, unlikely at this time. What would be more likely, however, is a federation of locally operated health care programs, either governmentally or privately based and subject to national guidelines and standards.

Should the direction be that of providing more services through the private sector, and should the perception of health care as a moral right continue to grow, it is inevitable that increased governmental regulation will be imposed upon the private sector as the provider of these rights. Should, however, basic medical services be provided by governmental units, preferably locally based, then the private sector could be expected to move increasingly into the area of offering supplemental services. While still subject to regulation, considerably more freedom could be expected by the private sector in this role than as the basic health care service provider for the nation.

The Future of Health Care

The only certainty at this time is that change in the manner and form of health care service delivery is inevitable. New systems of health care must recognize the limited ability of health care to insure health (as well as the possibility of causing harm), the important contribution of health care services in assuring a desired quality of life, and the need to focus increased amounts of health care service delivery on those populations that have experienced the greatest lack of such services in the past—the poor.

This future form of medical practice will be developed and carried out by the medical students of today. Such students are, in many respects, different from their predecessors. Arguing that this is as it should be, Dr. Fitzhugh Mullen, Director of the National Health Service Corps, states: "What is needed now is a generation of physicians trained with a significantly different set of skills, expectations, and professional allegiances."[23]

There is evidence today that this new breed of medical students has arrived. In the words of Renee Fox:

> [Medical students] are especially outspoken about the inadequacies and inequities in the nation's system of health care delivery, about the responsibility that they feel the established medical profession bears for the existence of these deficiencies and injustices, and about their own determination to play an active role as physicians in eliminating them.[24]

Today's student is concerned with the ethical implications of medical care, is concerned with distributive justice, is concerned with equity. This is as it should be, for these concerns will shape the practice of tomorrow.

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